EXHIBIT VV

Brookwood Medical Center Medical Records dated July, 2003

BROOKWOOD MEDICAL CENTER

HISTORY AND PHYSICAL

2010 BROOKWOOD MEDICAL CENTER DRIVE * BIRMINGHAM, ALABAMA * 35209

PATIENT: KELLEY, DANIEL
PHYSICIAN: HOWARD STRICKLER, M.D.~
ADMITTED: __/__/____
REFERRING PHYSICIAN:

ACCT #: 4258893
MR #: 000466636
ROOM #:

CHIEF COMPLAINT : DRUG PROBLEM.

HISTORY OF PRESENT ILLNESS: The patient is a 32 year-old white male who presented to the emergency room asking for help for his drug problem. He says he suffered fractured vertebra of L4-L5 and S1 in 4/01. He had to have a back operation. He continues to have back pain and has been told he needs a second operation. He says he has been smoking and snorting cocaine daily for the past week. He says he started back using cocaine 3 weeks ago. Prior to that he had been cocaine free for 5 months. He uses $40 to $200 dollars worth of cocaine per day. His last cocaine use was on the day prior to admission . He first tried cocaine at age 41. He takes 2 Lorcet every 4 hours. He says he will take 6-8 Lorcet per day. He has been taking Lorcet since 4/01. He takes one Soma each morning and has taken Soma for 5 ½ to 6 months. He takes 1 Xanax 1 mg tablet each evening and has taken Xanax for 5 or 6 months. Takes Seroquel for sleep 200 mg qhs. He has been taking Seroquel for 2 months because Ambien did not seem to help. He says he was an alcoholic 5 years ago but now only drinks 2 or 3 beers each evening and one pint of vodka per month. His last drink was on the day prior to admission . His last Soma was one week prior to admission . His last Xanax was one week prior to admission . His last Lortab was on the day of admission. No other drugs. He admits his alcohol and drug use have led to family problems, financial problems and memory problems. He had 2 DUIs years ago . He has had 4 or 5 arrests for public intoxication. He was charged once with 1st degree assault but the charge was dropped. When he is in withdrawal from alcohol and drugs he has mood swings, nervousness, chills, sweats, aching all over, abdominal cramping, diarrhea , muscle cramps and trouble sleeping. No history of seizures, hallucinations, suicide attempts. He was previously treated for his alcohol problem at Baptist Montclair 4-5 years ago . He stayed there 6 or 7 days then went to Lincoln Trails in KY for 21 days of treatment . He was able to stay alcohol free for one year after his treatment at Lincoln Trails.

PAST MEDICAL HISTORY: Hospitalization in Sylacauga 2 days prior to admission after being beaten up. He had bruises and blood in his urine. He stayed in the hospital 2 days then left to come here for treatment of chemical dependency. He says he has had surgery on both knees in the past. He has a rotator cuff injury of his right shoulder and has been receiving Cortisone shots. He has been told he needs a shoulder operation.

ALLERGIES: CODEINE.

He takes Aleve if he has no Lorcet.

SOCIAL HISTORY: Dips snuff. Has used snuff since 1989. Lives alone. Married once and divorced now. He has one daughter age 10. Completed high-school. Not presently employed. Disabled. He served in the Army and the National Guard starting in 1989 for 7 years.

FAMILY HISTORY: Mother is age 49 and in good health. Father is age 53 and has had a stroke. The patient has one brother who is in recovery from drug addiction. He says numerous uncles and cousins have had alcohol and drug problems.

REVIEW OF SYSTEMS: GI- problems with stomach ulcers off and on since age 12. Takes Aciphex.

BROOKWOOD MEDICAL CENTER
PATIENT: KELLEY, DANIEL
MR #: 000456536
ACCT #: 4256893

HISTORY AND PHYSICAL

PHYSICAL EXAMINATION:
GENERAL: In no acute distress. Well-developed, well-nourished, white male . Does appear depressed.
HEENT: Normocephalic, atraumatic. PERRLA. EOMI.
NECK: Supple without adenopathy , jugular venous distention or bruits.
HEART: Regular rate and rhythm .
LUNGS: Clear to auscultation.
ABDOMEN: Soft, nontender, nondistended , normal active bowel sounds.
EXTREMITIES : No clubbing, cyanosis, or edema .
SKIN: Within normal limits
NEUROLOGICAL : Cranial nerves 2-12 intact. Strength, sensory exam intact.

MENTAL STATUS EXAM: Appearance is average. Mood is depressed. Affect is blunted. Speech is normal. No hallucinations or delusions. Oriented to person, place, time and situation . Long and short term memory intact. Judgement is impaired by denial and rationalization. No homicidal ideation or suicidal ideation.

LABORATORY DATA: CBC within normal limits except for low RBCs of 4.14, low hematocrit of 41.6, elevated MCV of 100.5, elevated MCH of 34.6. Elevated RDW of 15.3 and low MPV of 7.7. Urinalysis = specific gravity 1.010, pH 6.0, dipstick negative. Microscopic negative except for moderate bacteria. Chem profile within normal limits . Urine drug screen positive for benzodiazepines, cocaine and opiates.

ASSESSMENT:
AXIS I:
Alcohol dependence.
Cocaine dependence.
Opiate dependence.
Mixed substance abuse.
Depression.
AXIS II:
No diagnosis .
AXIS III:
Chronic back pain.
Macrocytosis.
AXIS IV:
Severe psychosocial stressors.
AXIS V:
Present GAF 40. Best GAF this year not known.

PLAN: The patient is admitted for treatment of his chemical dependency and depression.

BROOKWOOD MEDICAL CENTER
PATIENT: KELLEY, DANIEL
MR #: 000456536
ACCT #: 4258893

HISTORY AND PHYSICAL

HOWARD STRICKLER, M.D.~

tr: wessc
dd: 07/31/2003 time: 02:11
dt: 07/31/2003 time: 11:07:05
job: 08946

EXHIBIT WW

Brookwood Medical Center Medical Records dated 09/09/03

BROOKWOOD MEDICAL CENTER

HISTORY AND PHYSICAL

2010 BROOKWOOD MEDICAL CENTER DRIVE * BIRMINGHAM, ALABAMA * 35209

PATIENT: KELLEY, DANIEL
PHYSICIAN: HOWARD STRICKLER, M.D.~
ADMITTED: 09/09/2003
REFERRING PHYSICIAN:

ACCT #: 4415394
MR #: 000456536
ROOM #: 717-1

CHIEF COMPLAINT: ALCOHOL AND DRUG PROBLEM

HISTORY OF PRESENT ILLNESS: Mr. Kelley is a 32 year old white male who presented to the Emergency Room asking for help again for his alcohol and drug problem. He was last admitted here about six weeks ago for treatment of his chemical dependency and depression. He says that he stayed drug free only two or three days after leaving the hospital. He later went to a program in Miami for one month for treatment of his chemical dependency but he says that he was allowed to drink beer in the treatment program in Miami. Since returning from Miami, he has been using alcohol and drugs again. He is now drinking alcohol daily consuming 1 ½ pints of whiskey per day. Her last drink was on the night of admission. He smokes crack Cocaine or snorts Cocaine daily using about $100.00 worth of Cocaine per day. His last Cocaine use was on the day of admission. He has been taking Xanax 7 or 8 mg per day. His last Xanax was two days prior to admission. He has been taking Lortab or Lorcet 6 or 7 pills per day. His last opiate use was on the day of admission. He says he has been depressed this time for two months. He says his last suicide thoughts were two hours ago. His last suicide attempt was on the day of admission. He says that he thought about shooting himself at that time and he got out a gun but his mother and father took the gun away. He has a long past history of alcohol and drug problems. He admits that his alcohol and drug use have lead to family problems, financial problems, and memory problems. He has had two DUI's years ago. He has had four or five arrests for public intoxication. He was charged once with first degree assault but the charge was dropped. When he is in withdrawal from alcohol and drugs, he has mood swings, nervousness, chills, sweats, aching all over, abdominal cramping, diarrhea, muscle cramps and trouble sleeping. No history of seizures, hallucinations. He was previously treated for his alcohol problem at Baptist Montclair five years ago. He stayed there for six or seven days, then went to Lincoln Trails in Kentucky for 21 days of treatment. He was able to stay alcohol free for one year after his treatment at Lincoln Trails.

PAST MEDICAL HISTORY: He has had surgery on both knees in the past. He has been told that he needs a right shoulder operation due to a rotator cuff injury.

ALLERGIES: HE IS ALLERGIC TO CODEINE

SOCIAL HISTORY: He dips snuff. He has used snuff since 1989. He has been living alone or with a girlfriend. He was married once and is divorced now. He has one daughter age 10. In school, he completed high school. He is not presently employed. He is disabled. He served in the Army and National Guard starting in 1989 for seven years.

FAMILY HISTORY: His mother is age 49 and she is in good health. His father is age 53 and he has had a stroke. Patient has one brother who is in recovery from drug addiction. He says numerous uncles and cousins have had alcohol and drug problems.

REVIEW OF SYSTEMS: GI: He has had problems with stomach ulcers off and on since age 12 and takes Aciphex. RESPIRATORY: He has had a recent productive cough. Review of systems otherwise negative.

PHYSICAL EXAMINATION:

GENERAL: He is a well-developed, well-nourished, unkempt appearing white male who appears depressed. He is alert and oriented x 4.
HEENT: Normocephalic. PERRL. EOM full. Mouth and throat clear.
NECK: No masses or tenderness.
LUNGS: Clear.
BACK: No CVA tenderness.
HEART: Normal sinus rhythm. No murmur.
ABDOMEN: Soft, nontender, no masses or organomegaly. Bowel sounds are normal.
EXTREMITIES: No edema or cyanosis.
SKIN: Within normal limits.
NEUROLOGICAL: Cranial nerves 2-12 intact. DTR's 1+ and equal bilaterally. Gait not evaluated at this time.

MENTAL STATUS EXAM: Appearance is unkempt. Mood is depressed. Affect is blunted. Speech is normal. There are no hallucinations or delusions. He is oriented to person, place, time and situation. Long-term and short-term memory are intact and immediate recall is intact. Judgement is average. No homicidal ideation. He has been having suicide thoughts and says his last suicide thoughts were two hours ago.

LABORATORY: Chemistry profile within normal limits except for low potassium of 3.4. CBC within normal limits except for low MPV of 8.3.

ASSESSMENT:

AXIS I:
1) Alcohol dependence.
2) Opiate dependence.
3) Cocaine dependence.
4) Benzodiazepine dependence.
5) Major depression.

AXIS II:
No diagnosis.

BROOKWOOD MEDICAL CENTER
PATIENT: KELLEY, DANIEL
MR #: 000456536
ACCT #: 4415394

HISTORY AND PHYSICAL

AXIS III:
1) Chronic back pain.
2) Bronchitis.

AXIS IV:
Severe psychosocial stressors.

AXIS V:
Present GAF 40, best GAF this year not known.

PLAN: The patient is admitted for treatment of his chemical dependency and depression. Sputum has been ordered for culture and he will be started on Zithromax for his bronchitis.

HOWARD STRICKLER, M.D.~

tr: smitc
dd: 09/10/2003 time: 20:34
dt: 09/11/2003 time: 21:06:28
job: 04987

EXHIBIT XX

Brookwood Medical Center Medical Records dated 01/23/04

BROOKWOOD MEDICAL CENTER

DISCHARGE SUMMARY

2010 BROOKWOOD MEDICAL CENTER DRIVE - BIRMINGHAM, ALABAMA - 35209

PATIENT: KELLEY, DANIEL B
PHYSICIAN: Douglas S. Dickinson, M.D.
ADMITTED: 1-20-04 DISCHARGED: 1-23-04

MR#: 456536
RM#:
ACCT#: ~~0456536~~ 2618275

DISCHARGE DIAGNOSES:
1. ACUTE HEPATITIS B - CHOLESTATIC.
2. BIPOLAR DISORDER.
3. GASTROESOPHAGEAL REFLUX DISEASE (GERD).
4. HISTORY OF BARRETT'S.
5. ANOREXIA AND NAUSEA ASSOCIATED WITH THE ABOVE.

SUMMARY: The patient was admitted on an urgent basis after being transferred from Russell Hospital in the Alexander City area. He apparently had been incarcerated and became jaundice and with loss of appetite and loss of weight. He has as previous history of drug abuse. He was placed in the hospital for positive cocaine while going for court hearing. In prison with the severe jaundice, lost appetite, and etc., he was brought to the local hospital there. In the jail he allegedly had a seizure. He was on multiple medications and high dosages in the hospital including Robaxin, phenobarbital, Zyprexa, Seroquel, Neurontin, and Klonopin. Prior to admission to the hospital the patient has been taking Lortab, Zyprexa, and Klonopin and apparently took some cocaine. The patient denies IV drug abuse. He is divorced. After being hospitalized here, his liver function test showed him to be positive for hepatitis B surface antigen. His ANA was negative. Alpha fetoprotein level was normal. _____ level was high. Serum ammonia level was normal. His bilirubin was 10.1, ALT 2596, direct bilirubin 7.8, protime 12.9. At the time of discharge his bilirubin was down to 4.3 and protime 12.3. The patient is being discharged on no medications. He is eating and holding down fluids adequately at the time of discharge. Ultrasound shows significant hepatomegaly, no evidence of ascites. The gallbladder is contracted but no stones. The common bile duct was not dilated. The patient is to recheck with me in the office in two weeks as an outpatient. I told him the only medication he can take is Benadryl at bedtime. I have encouraged him to stay off all other medications at this time.

Douglas S. Dickinson, M.D.
Dictated by: Douglas S. Dickinson, M.D.

TL: 057
DD: 01/23/04
DT: 01/23/04
JN: 27379